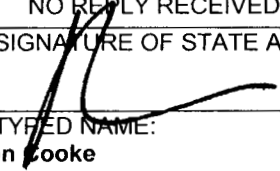



TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION		1. TRANSMITTAL NUMBER: 04 - 02	2. STATE: TEXAS
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: April 1, 2004	
5. TYPE OF PLAN MATERIAL (Circle One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: Title XIX of the Social Security Act, as amended; 42 CFR §431.110		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2004 \$ 1,305 b. FFY 2005 \$ 2,472	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: SEE ATTACHMENT		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): SEE ATTACHMENT	
10. SUBJECT OF AMENDMENT: This amendment adds the reimbursement methodology for outpatient services delivered to Native American Medicaid beneficiaries in qualified facilities. <div style="text-align: right; margin-top: 20px;"> <i>2442 (04-02)</i> <i>approved: 07/09/04</i> <i>effective: 04/01/04</i> </div>			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt. <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Jason Cooke State Medicaid/CHIP Director Post Office Box 13247 Austin, Texas 78711	
13. TYPED NAME: Jason Cooke			
14. TITLE: State Medicaid/CHIP Director			
15. DATE SUBMITTED: May 3, 2004			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 4 MAY 2004		18. DATE APPROVED: 9 JULY 2004	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 APRIL 2004		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: ANDREW A. FREDRICKSON		22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIV OF MEDICAID & CHILDREN'S HEALTH	
23. REMARKS:			

48. Reimbursement methodology for outpatient services provided in Indian Health Services facilities operating under the authority of P. L. 93-638.

For outpatient services provided to Native Americans by a qualified facility operated by the Indian Health Service or tribe, the applicable rate will be paid as published and specified by the Office of Management and Budget (OMB) in the Federal Register.

SUPERSEDES: NONE - NEW PAGE

STATE <u>Texas</u>	A
DATE REC'D <u>5-4-09</u>	
DATE APPV'D <u>7-9-09</u>	
DATE EFF <u>4-1-09</u>	
HCFA 179 <u>TX 09-02</u>	